## HealthSelect and CIGNA HMO Benefit Comparison Grid Summary

	HealthSelect	HealthSelect	CIGNA HMO	CIGNA HMO
	HIGH Option	LOW Option	HIGH Option	LOW Option
	•	•	'	in-inetwork Services Unity, Restricted to CIGNA
	In-Network Services Only	In-Network Services Only	In-Network Services Only; Restricted to CIGNA Clinics	Clinics
Standard Benefit Coverage				
Deductible				
Individual	None	None	None	None
Family	None	None	None	None
Standard Coinsurance % Covered by Plan	None	None	None	None
Out-of-Pocket Maximum (OOP)				
		\$5,000 OOP Maximum for inpatient & outpatient		\$5,000 OOP Maximum for inpatient & outpatient
Individual	None	facility copay	None	facility copay
		\$10,000 OOP Maximum for inpatient &		\$10,000 OOP Maximum for inpatient & outpatient
Family	None	outpatient facility copay	None	facility copay
Lifetime Maximum Benefit	None	None	None	None
Pre-existing Condition Limitation	None	None	None	None
General Services				1.1.1
Primary Care Physician Services	\$10 Copay	\$25 Copay	\$10 Copay	\$25 Copay
Specialty Care Physician Services	\$10 Copay	\$45 Copay	\$10 Copay	\$45 Copay
approximate of the orange of t	No Copay for lab or x-ray;	No Copay for lab or x-ray; \$100 Copay for MRI,	No Copay for lab or x-ray	No Copay for lab or x-ray; \$100 Copay for MRI, PET
Independent Lab & X-Ray Facility	\$25 Copay for MRI, PET & CT Scans	PET & CT Scans	\$50 Copay for MRI, PET & CT Scans	& CT Scans
Outpatient Surgery	No Copay	\$250 Copay, then covered at 90%	No Copay	\$250 Copay, then covered at 90%
Urgent Care Facility (Participating)	\$25 Copay if urgent, otherwise not covered	\$50 Copay if urgent, otherwise not covered	\$35 Copay if urgent, otherwise not covered	\$50 Copay if urgent, otherwise not covered
orgenicale raciity (Farticipating)	\$25 Copay ii digent, otherwise not covered	\$100 Copay if emergency, otherwise not	\$35 Copay if digent, otherwise not covered	\$30 Copay if digent, otherwise not covered
Emergency Room (Copay Waived if Admitted)	\$50 Copay if emergency, otherwise not covered	covered	\$75 Copay if emergency, otherwise not covered	\$100 Copay if emergency, otherwise not covered
Ambulance	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered	No Copay if emergency, otherwise not covered
Inpatient Hospitalization	No Copay ii emergency, otherwise not covered	No Copay if emergency, otherwise not covered	No Copay II emergency, otherwise not covered	No Copay if emergency, otherwise not covered
Facility Services	No Copay	\$500 Copay, then covered at 90%	No Copay	\$500 Copay, then covered at 90%
Physician & Surgeon's Services	No Copay No Copay	No Copay	No Copay	No Copay
Penalty for Not Getting Prior Authorization	No Copay None	No Copay None	None None	None None
Maternity	None	None	None	None
	On a constituted office detection	0	One and a first destrict	One and the details to
Prenatal & Postnatal Exams Hospital Delivery	Copay waived after 1st visit No Copay	Copay waived after 1st visit \$500 Copay; then covered at 90%	Copay waived after 1st visit No Copay	Copay waived after 1st visit \$500 Copay; then covered at 90%
Equipment & Devices	No Copay	\$500 Copay, then covered at 90%	140 Сорау	\$500 Copay, then covered at 90%
	N- 0(\$0.000i)	N- 0 (60 500i)	No Copay (\$3,500 maximum)	No Copay (\$3,500 maximum)
Durable Medical Equipment	No Copay (\$2,000 maximum)	No Copay (\$3,500 maximum)		
External Prosthetics & Orthotics	No Copay (\$2,000 maximum)	\$200 deductible (\$1,000 maximum)	No Copay (\$3,000 maximum)	\$200 deductible (\$1,000 maximum)
Outpatient Rehabilitation				
Physical, Speech, & Occupational Therapy	\$10 Copay; 60 visits combined maximum/year	\$45 Copay; 60 visits combined maximum/year	\$10 Copay; 60 visits combined maximum/year	\$45 Copay; 60 visits combined maximum/year
Chiropractic Services (chronic care not covered;	\$10 Copay		\$10 Copay	
must be medically necessary).	12 self-referral visits/year	\$45 Copay; 20 self-referral visits/year	20 self-referral visits/year	\$45 Copay; 20 self-referral visits/year
Alternative Medicines uses designated network	CE Conque 13 Colf referral visite has a	CE Canava 12 Calf referral visits/veer	CE Canaly 10 Calf referral visite/veer	OF Concus 10 Calf referral visits have
Alternative Medicine; uses designated network	\$5 Copay; 12 Self-referral visits/year	\$5 Copay; 12 Self-referral visits/year	\$5 Copay; 10 Self-referral visits/year	\$5 Copay; 10 Self-referral visits/year
Other Healthcare Facilities				
Skilled Nursing Facilities				
Subscriber Payment	No Copay	Covered at 90%	No Copay	Covered at 90%
			90 days/year combined SNF, Rehab Hospital & Sub-	90 days/year combined SNF, Rehab Hospital & Sub-
Limit per Contract Year	60 days per year	60 days per year	acute	acute
		L		
Home Health Care	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)	No Copay when medically necessary (unlimited)
Family Planning				
Sterilization				
Vasectomy	Place of Service Copay	Place of Service Copay	Place of Service Copay	Place of Service Copay
Tubal Ligation	Place of Service Copay	Place of Service Copay	Place of Service Copay	Place of Service Copay
	Place of Service Copay; Diagnostic Services &	Place of Service Copay; Diagnostic Services &	Place of Service Copay; Diagnostic Services &	Place of Service Copay; Diagnostic Services &
Infertility Services	Corrective Treatment Only	Corrective Treatment Only	Corrective Treatment Only	Corrective Treatment Only

### **2005** HealthSelect and CIGNA HMO Benefit Comparison Grid Summary

# Pharmacy Benefit Choices through Walgreens Health Initiatives You choose either the Coinsurance Rx Plan or the Consumer Choice Rx Plan

	Coinsurance Rx Plan		Consumer Choice Rx Plan	
Pharmacy	Medication Copay		CONSUMER CHOICE IX FIGH	
Retail (30-day supply)	Generic	25% of contract rate (minimum \$2, maximum \$12)	Level I Pharmacy Account	The account is funded 100% by Maricopa County at \$200/individual or \$400/family. Use this amount to
		30% of contract rate (minimum \$5, maximum		pay for prescription costs as you choose, and there is
	Preferred Brand Name	\$30)		no copay. This plan does not have an approved drug
	Non-Preferred Brand Name with generic	50% of contract rate plus the difference		list (formulary) but certain drugs require prior
	equivalent	between brand & generic cost (minimum \$20)		authorization or use of certain medications in a
	Non-Preferred Brand Name without generic			specific order (step therapy). Quantity level limits
	equivalent	50% of contract rate (minimum \$20)		apply to certain medications, & some drug classes, such as infertility & cosmetic medications, are
	Non-preferred specialty drugs	\$50 Copay		excluded. Any unused portion is rolled over to the
Advantage 90 (90-day supply)	Generic	25% of contract rate (minimum \$6; maximum \$36)		next benefit year. Amounts spent from the pharmacy account do not accumulate towards the
	Preferred Brand Name	30% of contract rate (minimum \$15; maximum \$90)		\$1,500/\$3,000 out-of-pocket maximum.
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)	Level II Employee Responsibility	You are responsible for the deductible, which begins
	Non-Preferred Brand Name without generic			after you have exhausted the funds in the Pharmacy
	equivalent	50% of contract rate (minimum \$60)		account and is funded 100% by you at the rate of \$200/individual or \$400/ family. You spend your
	Non-preferred specialty drugs	Not available in more than 30-day supply		deductible amount toward your prescription costs as
				you choose. If you have enrolled in the Mariflex
				flexible spending account, you can use your pre-
				taxed funds to pay for medication costs in this level.
		15% of contract rate (minimum \$6, maximum		Amounts spent towards the deductible accumulate
Mail Order (90-day supply)	Generic	\$28)		towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	25% of contract rate (minimum \$15, maximum \$70)	Level III Insurance	
				The insurance level covers the cost of the medication
	Non-Boofemand Boond Names with some six	500/ of		at 80% of the discounted cost of the medication. You
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		pay 20%. Amounts spent as coinsurance accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Non-Preferred Brand Name without generic	brand & generic cost (minimum \$00)	Level IV	towards the \$1,500/\$5,000 out-of-pocket maximum.
	equivalent	50% of contract rate (minimum \$60)	Specialty Medication	
	oquivalent	ee // er eendaet rate (minimum \$ee)	opolarly modification	Specialty pharmacy medications will not be charged
				against your pharmacy account or deductible.
				Instead, a \$50 copayment will be charged. The out-of
				pocket expense will be applied toward out-of-pocket
				maximums. Amounts spent as copayments for
	Non-preferred specialty drugs	\$50 for 30-day supply through home delivery service		specialty medications accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
Pharmacy Out-of-Pocket Maximum (OOP)	\$1,500 Individual/\$3,000	Family Maximum per year	Pharmacy Out-of-Pocket Maximum (OOP)	\$1,500 Individual/\$3,000 Family Maximum per year
Behavioral Health Benefit		United Behavioral	Health for all medical plans	
Vision Benefit			Plan for all medical plans	
Dependent Children Eligibility	Child must be unmarried and legally/financially dependent upon employee and/or spouse. Covered to age 19 unless full time student & then covered to age 25			

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#### **2005 POS (Point of Service ) Benefit Comparison Grid Summary**

	CIGNA POS	CIGNA POS	CIGNA POS	CIGNA POS
	HIGH Option	HIGH Option	LOW Option	LOW Option
	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
Standard Benefit Coverage	III-NELWOLK SELVICES	Out-oi-Network Services	III-NELWOIK SELVICES	Out-of-Network Services
Deductible				
Individual	None	\$300	None	\$1,000
Family	None	\$600	None	\$2.000
Standard Coinsurance % Covered by Plan	None	70% of Reasonable & Customary Charges	None	70% of Reasonable & Customary Charges
Out-of-Pocket Maximum (OOP)	None	70% of Reasonable & Customary Charges	None	70% of Reasonable & Customary Charges
Out-oi-Focket Maximum (OOF)	\$900 OOP Maximum for inpatient & outpatient	\$3,000 OOP Maximum for inpatient & outpatient	\$5,000 OOP Maximum for inpatient &	\$10,000 OOP Maximum for inpatient & outpatient facility
Individual	facility copays	facility deductibles	outpatient facility copays	deductibles
	\$1,800 OOP Maximum for inpatient & outpatient	\$6,000 OOP Maximum for inpatient & outpatient	\$10,000 OOP Maximum for inpatient &	\$20,000 OOP Maximum for inpatient & outpatient facility
Family	facility copays	facility deductibles	outpatient facility copays	deductibles
Lifetime Maximum Benefit	None	\$5 Million	None	\$1 Million
		12 months waiting period; creditable coverage		12 months waiting period; creditable coverage months may
Pre-existing Condition Limitation	None	months may decrease the period	None	decrease the period
General Services				
		70% after deductible; preventive care covered in-		
Primary Care Physician Services	\$15 Copay	network only	\$35 Copay	70% after deductible; preventive care covered in-network only
		70% after deductible; preventive care covered in-		
Specialty Care Physician Services	\$25 Copay	network only	\$50 Copay	70% after deductible; preventive care covered in-network only
	No Copay for lab or x-ray;	-	No Copay for lab or x-ray	· ·
Independent Lab and X-Ray Facility	\$50 Copay for MRI, PET & CT Scans	70% after deductible	\$200 Copay for MRI, PET & CT Scans	70% after deductible
Outpatient Surgery	\$100 Copay	70% after deductible	\$500 Copay, then covered at 90%	\$1,000/visit deductible & plan deductible, then covered at 70%
outputiont ourgery	ψ100 σοραγ	7070 unter deductible	\$75 Copay if urgent, otherwise 70% after	The second state of the second
Urgent Care Facility	\$50 Conay if urgent otherwise 70% after deductible	\$50 Copay if urgent, otherwise 70% after deductible	deductible	\$75 Copay if urgent, otherwise 70% after deductible
orgeni Care r aciiity	\$100 Copay if emergency, otherwise 70% after	\$100 Copay if emergency, otherwise 70% after	\$150 Copay if emergency, otherwise 70%	\$75 Copay if digent, otherwise 70% after deductible
Emergency Room (Copay Waived if Admitted)	deductible	deductible	after deductible	\$150 Copay if emergency, otherwise 70% after deductible
	No Copay if emergency, otherwise 70% after	No Copay if emergency, otherwise 70% after	No Copay if emergency, otherwise 70%	
Ambulance	deductible	deductible	after deductible	No Copay if emergency, otherwise 70% after deductible
Inpatient Hospitalization				
Facility Services	\$100/day, \$300 maximum/admission	70% after deductible	\$1,000 Copay, then covered at 90%	\$2,000/admission deductible plus plan deductible, then covered at 70%
Physician & Surgeon's Services	No Copay	70% after deductible	No Copay	70% after deductible
, , , , , , , , , , , , , , , , , , , ,		50% penalty applied to hospital inpatient charges;		50% penalty applied to hospital inpatient charges; benefits denied
Penalty for Not Getting Prior Authorization	None	benefits denied for outpatient services	None	for outpatient services
Maternity				=00/ 5 1 1 W
Prenatal & Postnatal Exams	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	70% after deductible
Hospital Delivery	\$100/day, \$300 maximum/admission	70% after deductible	\$1,000 Copay, then covered at 90%	\$2,000 deductible and plan deductible, then covered at 70%
Equipment & Devices				
Durable Medical Equipment	No Copay (\$3,500 maximum)	Covered in-network only	No Copay (\$3,500 maximum)	Covered in-network only
External Prosthetics & Orthotics	No Copay (\$3,000 maximum)	Covered in-network only	\$200 deductible (\$1,000 maximum)	Covered in-network only
Outpatient Rehabilitation				
		70% after deductible; 60 visits combined	\$50 Copay; 60 visits combined	
Physical, Speech, & Occupational Therapy	\$15 Copay; 60 visits combined maximum/year	maximum/year	maximum/year	70% after deductible; 60 visits combined maximum/year
Chiropractic Services (chronic care not covered;	\$15 Copay		\$50 Copay	
must be medically necessary).	20 self-referral visits/year	Covered in-network only	20 self-referral visits/year	Covered in-network only
Alternative Medicine; uses designated network	\$5 Copay; 10 Self-referral visits/year	Covered in-network only	\$5 Copay; 10 Self-referral visits/year	Covered in-network only
Other Healthcare Facilities				
Skilled Nursing Facilities				
Subscriber Payment	No Copay	70% after deductible	90% coinsurance after deductible	70% after deductible
Limit per Contract Year	90 days per year	90 days/year combined SNF, Rehab Hospital & Sub- acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute
. p =		2.500	No Copay when medically necessary	The state of the s
Home Health Care	No Copay when medically necessary (unlimited)	70% after deductible; 40 days/year	(unlimited)	70% after deductible; 40 days per year
Family Planning			,	
Sterilization				
	Place of Service Copay	70% after deductible	Place of Service Copay	70% after deductible
Vasectomy		7 0 /0 attor academic		
Vasectomy Tubal Ligation		70% after deductible	Place of Service Consy	70% after deductible
Vasectomy Tubal Ligation	Place of Service Copay  PCP or Specialist Copay; Diagnostic Services &	70% after deductible	Place of Service Copay Place of Service Copay; Diagnostic	70% after deductible

#### 2005 POS (Point of Service ) Benefit Comparison Grid Summary

## Pharmacy Benefit Choices through Walgreens Health Initiatives You choose either the Coinsurance Rx Plan or the Consumer Choice Rx Plan

		e Comsulance Ex Flam of the		
Coinsurance Rx Plan		Consumer Choice Rx Plan		
Pharmacy	Medication	Сорау		
Retail (30-day supply)	Generic	25% of contract rate (minimum \$2, maximum \$12)	Level I Pharmacy Account	The account is funded 100% by Maricopa County at
	Preferred Brand Name	30% of contract rate (minimum \$5, maximum \$30)	_	\$200/individual or \$400/family. Use this amount to pay for prescription costs as you choose, and there is no copay. This
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$20)		plan does not have an approved drug list (formulary) but certain drugs require prior authorization or use of certain medications in
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$20)		a specific order (step therapy). Quantity level limits apply to certain medications, & some drug classes, such as infertility &
	Non-preferred specialty drugs	\$50 Copay	-	cosmetic medications, are excluded. Any unused portion is rolled over to the next benefit year. Amounts spent from the pharmacy
Advantage 90 (90-day supply)	Generic	25% of contract rate (minimum \$6; maximum \$36)	_	account do not accumulate towards the \$1,500/\$3,000 out-of- pocket maximum.
	Preferred Brand Name	30% of contract rate (minimum \$15; maximum \$90)		
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)	Level II Employee Responsibility	You are responsible for the deductible, which begins after you have exhausted the funds in the Pharmacy account and is
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)		funded 100% by you at the rite of \$200/individual or \$400/ family You spend your deductible amount toward your prescription
Mail Order (90-day supply)	Non-preferred specialty drugs  Generic	Not available in more than 30-day supply  15% of contract rate (minimum \$6, maximum \$28)		costs as you choose. If you have enrolled in the Mariflex flexible spending account, you can use your pre-taxed funds to pay for medication costs in this level. Amounts spent towards the deductible accumulate towards the \$1,500/\$3,000 out-of-pocket maximum.
	Preferred Brand Name	25% of contract rate (minimum \$15, maximum \$70)	Level III Insurance	The insurance level covers the cost of the medication at 80% of the discounted ost of the medication. You pay 20%. Amounts
	Non-Preferred Brand Name with generic equivalent	50% of contract rate plus the difference between brand & generic cost (minimum \$60)		spent as coinsurance accumulate towards the \$1,500/\$3,000 out- of-pocket maximum.
	Non-Preferred Brand Name without generic equivalent	50% of contract rate (minimum \$60)	Level IV Specialty Medication	Specialty pharmacy medications will not be charged against your pharmacy account or deductible. Instead, a \$50 copayment will
	, ,	\$50 for 30-day supply through home delivery service		be charged. The out-of-pocket expense will be applied toward out of-pocket maximums. Amounts spent as copayments for specialty medications accumulate towards the \$1,500/\$3,000 out of-pocket maximum.
Pharmacy Out-of-Pocket Maximum	\$1,500 Individual/\$3,000	\$1,500 Individual/\$3,000 Family Maximum per year Pharmacy Out-of-Pocket Maximum \$1,500 Individual/\$3,000 Family Maximum per year		
Behavioral Health Benefit		United Behavioral Health for all medical plans		
Vision Benefit		AVESIS Vision Plan for all medical plans		
Dependent Children	Child must be unmarried and legally/financially dependent upon employee and/or spouse. Covered to age 19 unless full time student & then covered to age 25			

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### **2005 PPO (Preferred Provider Organization) Benefit Comparison Grid Summary**

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	CIGNA PPO	CIGNA PPO	CIGNA PPO	CIGNA PPO
	HIGH Option	HIGH Option	LOW Option	LOW Option
	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
Standard Benefit Coverage				
Deductible				
Individual	\$250	\$750	\$1,100	\$1,100
Family	\$500	\$1,500	\$2,200	\$2,200
Standard Coinsurance % Covered by Plan	80% of contracted rate	60% of Reasonable & Customary Charges	80% of contract rate	60% of Reasonable & Customary Charges
Out-of-Pocket Maximum (OOP)		7	80 % Of Contract rate	00 % of Reasonable & Customary Charges
	\$2,000 OOP Maximum applies to	\$4,000 OOP Maximum applies to		
Individual	coinsurance	coinsurance	\$5,000 OOP Maximum applies to coinsurance	\$5,000 OOP Maximum applies to coinsurance
	\$6,000 OOP Maximum applies to	\$12,000 OOP Maximum applies to		
Family	coinsurance	coinsurance	\$10,000 OOP Maximum applies to coinsurance	\$10,000 OOP Maximum applies to coinsurance
Lifetime Maximum Benefit	None	\$5 Million	\$5 Million	\$5 Million
	12 months waiting period; creditable	12 months waiting period; creditable	12 months waiting period; creditable coverage	12 months waiting period; creditable coverage months
Pre-existing Condition Limitation	coverage months may decrease the period	coverage months may decrease the period	months may decrease the period	may decrease the period
General Services				
		60% after deductible; preventive care		60% after deductible; preventive care covered in-
Primary Care Physician Services	80% after deductible	covered in-network only	80% after deductible	network only
		60% after deductible; preventive care		60% after deductible; preventive care covered in-
Specialty Care Physician Services	80% after deductible	covered in-network only	80% after deductible	network only
Independent Lab and X-Ray Facility	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Jan		\$50 copay if urgent, deductible waived,		
Urgent Care Facility	\$50 Copay; deductible waived	otherwise 60% after deductible	80% after deductible	80% after deductible if urgent, otherwise 60%
organic data r damey	goo copay, academic trained	\$100 Copay if emergency, deductible	oo /o antor academore	oo /o artor adaddasio ir argorit, daror mod oo /o
Emergency Room (Copay Waived if Admitted)	\$100 Copay; deductible waived	waived, otherwise 60% after deductible	80% after deductible	80% after deductible if emergency, otherwise 60%
Emergency Room (Gopay Waived in Admitted)	ψ100 σοραγ, deddetible waived	90% after deductible if emergency, otherwise	00 % after deductible	80% after deductible if emergency, otherwise 60% after
Ambulance	90% after deductible	60% after deductible	80% after deductible	deductible
Inpatient Hospitalization	30 % after deductible	00 % after deductible	00 % after deductible	deductible
Facility Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physician & Surgeon's Services	80% after deductible			60% after deductible
Physician & Surgeon's Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
		50% penalty applied to hospital inpatient		
D 11 6 N 10 11 D: A 11 : 11	.,	charges; benefits denied for outpatient	.,	50% penalty applied to hospital inpatient charges;
Penalty for Not Getting Prior Authorization	None	services	None	benefits denied for outpatient services
Maternity				
Prenatal & Postnatal Exams	80% Coinsurance, waived after 1st visit	60% after deductible	80% after deductible	60% after deductible
Hospital Delivery	80% after deductible	60% after deductible; Precertification	80% after deductible	60% after deductible; Precertification required
Equipment & Devices				
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
External Prosthetics & Orthotics	80% after deductible (\$3,000 maximum)	60% after deductible (\$3,000 maximum)	80% after deductible	60% after deductible
Outpatient Rehabilitation				
·	80% after deductible; 60 visits combined	60% after deductible; 60 visits combined	80% after deductible; 60 visits combined	60% after deductible; 60 visits combined
Physical, Speech, & Occupational Therapy		maximum/year	maximum/year	maximum/year
Physical, Speech, & Occupational Therapy Chiropractic Services (chronic care not covered;				
must be medically necessary).	80% after deductible; unlimited	60% after deductible; unlimited	80% after deductible; unlimited	60% after deductible; unlimited
Alternative Medicine; uses designated network	CE Coppy 10 Colf referred visits have	Covered in-network only	CE Conow 10 Colf referred visite has	Covered in-network only
	\$5 Copay; 10 Self-referral visits/year	Covered in-network only	\$5 Copay; 10 Self-referral visits/year	Covered in-network only
Other Healthcare Facilities				
Skilled Nursing Facilities				
Subscriber Payment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Limit per Contract Year	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub-acute	90 days/year combined SNF, Rehab Hospital & Sub- acute
Home Health Care	80% after deductible	60% after deductible; 40 days/year	80% after deductible	60% after deductible
Family Planning	00 /0 arter deductible	50 /0 alter deductible, 40 days/year	00 /0 ditel deductible	00 /0 alter deductible
Sterilization	000/ =#== 1 1 271	000/ - # 1 1 1111	000/ -# ! ! !!!!	000/ -65 1 1 1111
Vasectomy	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Tubal Ligation	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Infantility Complete		60% after deductible; Diagnostic Services &	Net Comment	Net Comment
Infertility Services	Corrective Treatment Only	Corrective Treatment Only	Not Covered	Not Covered

#### 2005 PPO (Preferred Provider Organization) Benefit Comparison Grid Summary

#### Pharmacy Benefit Choices through Walgreens Health Initiatives You choose either the Coinsurance Rx Plan or the Consumer Choice Rx Plan Coinsurance Rx Plan Consumer Choice Rx Plan Medication Copay Pharmacy Level I 25% of contract rate (minimum \$2, Retail (30-day supply) maximum \$12) **Pharmacy Account** Generic The account is funded 100% by Maricopa County at 30% of contract rate (minimum \$5, maximum \$200/individual or \$400/family. Use this amount to pay Preferred Brand Name for prescription costs as you choose, and there is no 50% of contract rate plus the difference copay. This plan does not have an approved drug list Non-Preferred Brand Name with generic between brand & generic cost (minimum (formulary) but certain drugs require prior authorization equivalent \$20) or use of certain medications in a specific order (step therapy). Quantity level limits apply to certain Non-Preferred Brand Name without generic medications, & some drug classes, such as infertility & 50% of contract rate (minimum \$20) equivalent cosmetic medications, are excluded. Any unused Non-preferred specialty drugs \$50 Copay portion is rolled over to the next benefit year. Amounts 25% of contract rate (minimum \$6; maximum spent from the pharmacy account do not accumulate \$36) Advantage 90 (90-day supply) Generic towards the \$1,500/\$3,000 out-of-pocket maximum. 30% of contract rate (minimum \$15; Preferred Brand Name maximum \$90) 50% of contract rate plus the difference You are responsible for the deductible, which begins Non-Preferred Brand Name with generic between brand & generic cost (minimum Level II after you have exhausted the funds in the Pharmacy equivalent \$60) **Employee Responsibility** account and is funded 100% by you at the rate of \$200/individual or \$400/ family. You spend your Non-Preferred Brand Name without generic deductible amount toward your prescription costs as equivalent 50% of contract rate (minimum \$60) you choose. If you have enrolled in the Mariflex flexible Non-preferred specialty drugs Not available in more than 30-day supply spending account, you can use your pre-taxed funds to pay for medication costs in this level. Amounts spent 15% of contract rate (minimum \$6, maximum towards the deductible accumulate towards the Mail Order (90-day supply) Generic \$1,500/\$3,000 out-of-pocket maximum. 25% of contract rate (minimum \$15. Level III maximum \$70) Preferred Brand Name Insurance The insurance level covers the cost of the medication 50% of contract rate plus the difference at 80% of the discounted cost of the medication. You Non-Preferred Brand Name with generic between brand & generic cost (minimum pay 20%. Amounts spent as coinsurance accumulate equivalent \$60) towards the \$1,500/\$3,000 out-of-pocket maximum. Non-Preferred Brand Name without generic Level IV Specialty pharmacy medications will not be charged equivalent 50% of contract rate (minimum \$60) **Specialty Medication** against your pharmacy account or deductible. Instead a \$50 copayment will be charged. The out-of-pocket expense will be applied toward out-of-pocket maximums. Amounts spent as copayments for specialty \$50 for 30-day supply through home delivery medications accumulate towards the \$1,500/\$3,000 out Non-preferred specialty drugs service of-pocket maximum. \$1.500 Individual/\$3.000 Family Maximum per year Pharmacy Out-of-Pocket Maximum \$1,500 Individual/\$3,000 Family Maximum per year Pharmacy Out-of-Pocket Maximum Behavioral Health Benefit United Behavioral Health United Behavioral Health Cigna Behavioral Health CIGNA Behavioral Health Vision Benefit AVESIS Vision Plan for all medical plans Dependent Children Child must be unmarried and legally/financially dependent upon employee and/or spouse. Covered to age 19 unless full time student & then covered to age 25

The plan documents under links on the Benefits Home page, located at www.maricopa.gov/benefits or ebc.maricopa.gov/hr/benefits, provide a complete description of benefits. These official documents govern if there is a discrepancy between the information on this comparison spreadsheet & the plan documents.